



Patient: _____

Date: _____

Today Was	Poor 1	Fair 2	Good 3	Very Good 4	Excellent 5
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Today's activities (circle)	Work	Sports	Exercise	Home duties	Fun
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Today I Was (Circle)	Happy Energetic	Upset Nervous	Depressed Worried	Tired Fatigue	Hopeless Stressed
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Symptom:

- Headache
- Muscle Spasm
- Weakness
- Lack of coordination
- Numbness
- Eye Problems
- Fatigue
- Bladder/Bowel
- Tremors
- Sexual problems
- Other type of pain

Flexibility:

- Unlimited movement - normal
- Movement limited by pain/fatigue
- Totally restricted
- Walking aid required
- Wheelchair required

Medications:

- No medications
- Mild analgesics, NSAID's
- Relaxants, antidepressants
- Other _____

Comments: _____

Sleep and Fatigue:

- Slept well – awoke rested
- Adequate sleep- awoke tired
- Inadequate, disturbed sleep
- Insomnia
- Hours of sleep _____

Psychological/Depression:

- None to mild
- Moderate
- Other _____

Ability to function:

- Able to function – unlimited
- Able to function – part time
- Limited to work schedule only
- Unable to function in any capacity

Current Medications:

Comments:

On a scale of 0 – 10, I was _____